COVID-19 SCREENING QUESTIONS

1. **Have you, your child, or anyone you or your child have been in close contact with (within 6 feet for more than 10 minutes), had <u>any</u> of the following symptoms: An Unexplained Temperature (of 100.4 or above), Cough, Shortness of Breath, or Difficulty Breathing in the past 14 days?**

   Yes or No

2. **Have you, your child, or anyone you or your child have been in close contact with (within 6 feet for more than 10 minutes), had <u>at least two</u> of the following symptoms: Fever, Chills (including repeated shaking), Muscle Pain, Headache, Sore Throat, New Loss of Taste or Smell in the past 14 days?**

   Yes or No

3. **Have you, your child, or anyone you or your child have been in close contact with (within 6 feet for more than 10 minutes), had direct contact with a confirmed COVID-19 individual in the past 14 days?**

   Yes or No

If you answered YES to ANY of these questions, STOP:

- **Call (208) 533-3235 to reschedule today's appointment.**
- **We will honor the waived fees**

If you answered NO to *ALL* of these questions, PROCEED to next page.

Child's Name: _____Child's Age: _____

CONTACT AND INSURANCE INFORMATION

PREFERRED LANGUAGE: English __ Spanish __ Other _____ NEEDS AN INTERPRETER: Yes ____ No____

CELL PHONE #: _____ HOME PHONE #: _____ E-MAIL: _____
PREFERRED CONTACT: CELL PHONE ___ HOME PHONE ___ E-MAIL ___
EMERGENCY CONTACT: _____ Contact # _____

DOES YOUR CHILD HAVE INSURANCE/MEDICAID/MEDICARE: YES___ No ____

- **If no, you may skip the highlighted section.**
- **If yes and you brought a COPY (front and back) of your child's insurance card for us to keep, you may skip the highlighted section.**
- **If yes and you did NOT bring a copy of the front and back of your child's insurance card, you MUST complete the highlighted section.**

Insurance Company_____
Claims Mailing Address_____
Provider Phone #_____
Policy #_____
Group# _____
Policy Holder's Name _____
Policy Holder's Date of Birth_____
Policy Holder's Relationship to Patient _____

RACE: Caucasian___ African American or Black___ American Indian___ Asian ___ Declined ___ Other___

ETHNICITY: Hispanic/Latino ____ Not Hispanic/Latino ___ Declined____

Child's Name: _____Child's Age: _____

Childhood Free Immunization Clinic Consent Form

June ___, 2020

In order for your child to obtain the vaccinations during this clinic, you must:

☐ **1. Complete** this form ☐ **3. Provide** copy of Insurance/Medicaid card

☐ **2. Sign & Date** this form ☐ **4. Provide** copy of all prior vaccination records

ATTACH A COPY OF MEDICAID OR INSURANCE IDENTIFICATION CARD. INSURANCE/MEDICAID WILL BE BILLED FOR VACCINE ADMINISTRATION FEES.

A. Information about person receiving vaccine (Please print)

Child's Full Legal Name Last_____ First_____ Middle_____

Child's Birth Date_____ Age _____ Gender Male Female Phone #_____

Parent/Guardian Name Last_____ First_____ Relationship_____

Child's Address_____ City_____ Zip Code_____ County _____

Insurance Company: _____**Insurance Phone Number:** _____

Insurance Company Address: _____

Policy/ID Number: _____**Group Number:** _____

Policy Holder Name: _____**Policy Holder DOB:** _____

Policy Holder Employer: _____

B. Vaccine Eligibility Screening (Please check appropriate box)

- ☐ **Medicaid:** A child, 0 thru 18 years of age, who has Medicaid coverage.
- ☐ **American Indian/Alaskan Native:** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance coverage.
- ☐ **No Health Insurance:** A child, 0 thru 18 years of age, who does not have health insurance.
- ☐ **Limited Health Insurance:** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccinations.
- ☐ **Insured:** A child, 0 thru 18 years of age, who has health insurance which provides coverage for vaccines.

C. Vaccine Health Screening (circle **Yes** or **No**)

Please answer all questions about the child who will be receiving the vaccine(s). Answers will determine whether the child can be vaccinated at this time. **If you respond 'Yes' to any of the questions, please explain in the space provided below.**

Yes	No	1. Does the child have any allergies to medication, foods, or any vaccines?
Yes	No	2. Has the child had a serious reaction to a vaccine in the past?
Yes	No	3. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes	No	4. Has the child had a seizure, brain, or other nervous system problem, including Guillain-Barré Syndrome?
Yes	No	5. Does the child have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes	No	6. Has the child taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes	No	7. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?
Yes	No	8. Is the child pregnant or is there a chance she could become pregnant during the next month?
Yes	No	9. Has the child received vaccinations in the past four (4) weeks?

Please explain any 'Yes' responses._____

D. Consent to Vaccinate

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for all of the indicated age appropriate vaccines that could be given. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and I consent for my child to receive any vaccine the Advisory Committee on Immunization Practices (ACIP) recommends that he/she is due for.

- **If I *<u>do not</u>* want my child to receive a specific age appropriate ACIP recommended vaccine, I will list it/them below.**

_____**Initials**_____

Child's Name: _____Child's Age: _____

E. FINANCIAL

By signing below, I consent to third party billing, including payment of insurance benefits to EIPH. I understand that any balance remaining will be waived off at no additional cost to me.

F. TREATMENT AND VACCINES

- I give permission to EIPH and/or their designees to vaccinate the person named on this form.
- I understand that immunizations are not mandatory and may be refused on religious or other grounds without reprisal. I understand additional information regarding vaccine(s) is available to me at EIPH. I understand the benefits and risks of vaccine(s) and ask that vaccine(s) be given to me or the person for whom I am authorized to make this request.
- I understand participation in and withdrawal from the immunization registry is voluntary. If you want to opt out or withdraw from Idaho's immunization registry (IRIS), call the Idaho Immunization Program at 208.334.5931.
- I understand that in order to prevent injury from falling due to post-vaccination fainting, it is recommended that I sit in the lobby for 15 minutes before exiting the building.
- I authorize the release of my minor child's (until 18 yrs.) immunization records to clinics, physician offices, daycares and school. My authorization rights are available to me in EIPH's Notice of Privacy Practices.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/PRIVACY PRACTICES

EIPH is required by law to maintain the privacy of your health information. Your information will be used for the purpose of treatment, payment, and EIPH business. You may request a copy of EIPH's privacy practices at any time. Individuals who pay in full out of pocket for an item or service may request that their protected health information is not shared with their health insurance or health plan.

If you believe your privacy rights have been violated, you may file a written complaint to the Secretary of the Department of Health and Human Services or to:

Privacy Officer: Eastern Idaho Public Health, 1250 Hollipark Drive, Idaho Falls, ID 83401

SIGNATURE

By signing, I confirm that I have:

- Read and understand the above information
- Been offered a copy of EIPH's HIPAA Privacy Practices
- Been offered a copy of EIPH's Financial Policy
- Been offered Vaccine Information Statements (VIS's)
- VIS's can be accessed at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

_____ _____

Signature of Consent **Date**

How did you hear about the free clinic you are attending today? Please mark all that apply.

	The radio		EIPH Website
	Friend or family referral		Facebook or Instagram
	School text		EIPH staff referral
	School email		Daycare
	Flyer		Other:

Did you see the free immunization clinic poster advertised on Facebook or Instagram?
YES or NO
(Please circle one)

Child's Name: _____Child's Age: _____

****DO NOT WRITE BELOW THIS LINE****

G. To be completed by person administering vaccine

Dx Code	Payer Source & Codes		Vaccination Date: / /2020
Encounter for Immunization **Screen – No Imms Needed (No Charge)**	**Insurance** **Medicaid** **90471** **90472 ___** **90473 1st Oral/Nasal**	**VFC (SL)** **90471 $0 90472 $0** **90472 _1_$0 _2_$0 _3_$0** **90473 1st Oral/Nasal $0**	**Per Antigen** **90460 Units_____** **90461 Units_____** **Total Amount Due** **$_____**

Vaccine		Lot Number	Provider Name	Site	Route
90620	**Bexsero**			Left Right Deltoid	IM
90700	**Dtap**			Left Right Deltoid Leg	IM
90674	**Flucelvax**			Left Right Deltoid Leg	IM
90686	**Flulaval 6 mo & up**			Left Right Deltoid Leg	IM
90633	**Hep A**			Left Right Deltoid Leg	IM
90744	**Hep B**			Left Right Deltoid Leg	IM
90651	**HPV**			Left Right Deltoid Leg	IM
90713	**IPV**			Left Right Deltoid Leg Arm	IM SQ
90696	**Kinrix**			Left Right Deltoid Leg	IM
90734	**Menactra**			Left Right Deltoid	IM
90707	**MMR**			Left Right Arm Outer Thigh	SQ
90710	**Proquad (MMRV)**			Left Right Arm	SQ
90723	**Pediarix**			Left Right Deltoid Leg	IM

Child's Name: _____Child's Age: _____

Vaccine		Lot Number	Provider Name	Site	Route
90647	**Pedvax**			Left Right Deltoid Leg	IM
90670	**Prevnar 13**			Left Right Deltoid Leg	IM
90680	**Rotateq**			Oral	Oral
90715	**Tdap**			Left Right Deltoid	IM
90621	**Trumenba**			Left Right Deltoid	IM
90636	**Twinrix**			Left Right Deltoid	IM
90716	**Varicella**			Left Right Arm Outer Thigh	SQ
				Left Right Deltoid Leg Arm	IM SQ
				Left Right Deltoid Leg Arm	IM SQ

Screening Reviewed and Education Provided by:_____

Antigen Counseling Provided by Allison Barto PA-C

Initial: _____Date: _____

Checked In ☐ Scanned ☐ SuperBilled ☐ Check out ☐ Historical ☐

05/2020 TL